



**Surprise Fire-Medical Department**  
14250 W. Statler Plaza Ste. 101  
Surprise, AZ 85374-7479  
Phone: 623-222-5000  
Fax: 623-222-5001



## **MEDICAL TRANSPORT FEE HARDSHIP WAIVER**

### **REQUEST FOR TRANSPORT FEE HARDSHIP WAIVER**

***A NEW HARDSHIP APPLICATION MUST BE SUBMITTED FOR EACH EMS TRANSPORT***

Transported/ Treated Patient Name: \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address:

\_\_\_\_\_  
\_\_\_\_\_

Applicant Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Monthly Household Gross Income: \_\_\_\_\_ Number of Dependents living in Household: \_\_\_\_\_

List of attached suggested supporting documentation:

- ☐ W-2 withholding statements or unemployment check stubs for the past 90 days
- ☐ Copies of three current paystubs from the Head of Household
- ☐ Income tax return (most recent signed 1040 and/or W-2)
- ☐ Unemployment check stubs or Notarized statement of unemployment
- ☐ Application forms from Medicaid or other State-funded medical assistance program
- ☐ Documentation of catastrophic illness affecting financial solvency
- ☐ Other (list): \_\_\_\_\_

Responsible Party (if different from applicant)

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address (if different from applicant):

\_\_\_\_\_  
\_\_\_\_\_

I do hereby request that I, as applicant or the party who is financially responsible for the applicant, be considered for a reduction in the payment responsibilities as they relate to this Medical Transport Service Fee. By signing this form I certify that I have no insurance that can be billed for this charge. I declare that all of the information contained in this document and the attachments are true and accurate. Further I understand that I may be held liable for any false statements pertaining to this waiver request. I hereby agree to notify the Surprise Fire-Medical Department of any change in the financial status of the applicant or the responsible party that may affect the ability to pay this Medical Transport Service Fee.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

For questions regarding the hardship waiver process, call (623)-222-5024 or e-mail  
[MedicalServices@surpriseaz.gov](mailto:MedicalServices@surpriseaz.gov)

**Mail completed applications and supporting documents to:**

Surprise Fire-Medical Department  
Attn: Medical Billing Manager  
14250 W. Statler Plaza, Ste. 101  
Surprise, AZ 85383

Administrative Use Only

Incident # \_\_\_\_\_ Invoice # \_\_\_\_\_  
Date of Service: \_\_\_\_\_ Date Received: \_\_\_\_\_  
Waiver Disposition (circle) Approved Denied Reason: \_\_\_\_\_

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Approval Signature \_\_\_\_\_ Vendor Notified: \_\_\_\_\_